# A STUDY ON QUALITY OF LIFE AND SOCIAL SUPPORT BREAST CANCER WOMEN IN GREATER CORPORATION OF CHENNAI

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## ARTICLE INFO

## ABSTRACT

The diagnosis of cancer created a fear and shock to their well balanced life and most of them felt that they were a burden on their family. Respondents followed an advanced allopathic regimen of treatment and however they enquired about alternative treatment like Ayurveda, homeopathy etc. Women knew about the illness as this study was conducted in a group of population where more number of educated women took part of it and those who have access to tertiary care facilities. It was found that most of the respondents got information about treatment. The difficulty of breast cancer leads to imposition of a lot of psychosocial problems. Respondents had fear about the disease, and its recurrence and subsequently they were in regular follow-ups. Most of them know the importance of regular follow-ups, they did not have an idea about the availability of breast prosthesis which would improve their cosmetic appearance and boost their confidence and had little opportunity to indulge in group sessions. Respondents have shared their feelings with others in their sad time. In our study most of the respondents did mix freely with others post treatment and have received more support from family, however they have felt that their disease has affected their children's marriage and relationship with their spouse. But most of them felt this disease has had effect on their children's marriage and education. This present study has several key points. It was found that breast cancer incidence was more in urban area.

## INTRODUCTION

The word cancer is derived from the Latin word, Cancrum which means a crab. Cancer may affect people at all ages, even foetuses but risk for the common variety trends to increase with age. Cancer causes about 13% of all deaths. The oldest treatment for malignancy is surgery, but there is now an increase range of nonsurgical treatments, encompassing both radiotherapy and drug treatments (Chemotherapy)[1]. Malignancy is common, developing at some time in life of more than one-third of population. It is the second most common cause of death in the western world after cardiovascular disease. However, there is significant variation with age, sex and geography in the incidence of the various malignancies as well as in the resources available for detection and treatment and amongst the more common solid tumours are lung and breast cancer[2].

### 1.1 Epidemiology of Cancer

Epidemiology of cancer determines the frequency and distribution of a disease and other health related events in a defined population. Epidemiological studies enable trends to be monitored over time and draws attention to deviations from normal patterns in subpopulations. Examples of epidemiological factors that may affect the occurrence of cancer are age, gender, race and geography.

### 1.2 Environmental Factors that Contribute to Cancer Development

A carcinogen is an agent capable of increasing the incidence of neoplasms above that experienced in the absence of the agent. Carcinogens generally refer to environmental factors, including naturally occurring and synthetic chemicals present in food, air, water and radiation.

### 1.3 Environmental Carcinogens

- Chemical Carcinogens
- Radiation
- Exogenous Hormones
- Dietary factors.

### 1.4 Breast Cancer

Breast Cancer is a malignant (Cancer) tumour that starts from cells of the breast. It is found mostly in women, but men can get breast cancer, too.

### 1.5 The Breasts

In each breast, there are 15 to 20 lobes which are arranged in a formation similar to that of a daisy. Each lobe consists of many smaller lobules, which end in many tiny bulb structures which are capable of producing milk. The lobes, lobules and bulbs are joined together by thin tubes called ducts. The ducts meet at the nipple located at the centre of the areola which is the dark area of skin[3]. Though, there are no muscles in the breast, there are muscles that lie under each breast covering the ribs. Breast tissue contains blood vessels and vessels containing lymph. These lymph vessels lead to small bean shaped organs which are known as lymph nodes. Lymph clusters can be found in the chest, under the arm and above

the collar bone, they are also found in many parts of the body. Breast cancer is the most common malignancy among women and the second leading cause cancer deaths among women[4].

## 1.6 Breast Cancer Terms

### (a) Carcinoma

This is a term used to describe a cancer that begins in the lining layer of organs such as the breast. Nearly all breast cancers are carcinomas (either ductal carcinomas or lobular carcinomas).

### (b) Adenocarcinoma

An adenocarcinoma is a type of cancer that starts in gland tissue (tissue that makes and secretes a substance). The ducts and lobules of the breast are gland tissues because they make breast milk, so cancers starting in these areas are often called adenocarcinomas.

### (c) Carcinoma in Situ

This term is used for the early stage of cancer, when it is still only in the layer of cells where it began. In breast cancer, in situ means that the cancer cells are only in the ducts (Ductal carcinoma in situ) or lobules (lobular carcinoma in situ). They have not spread into deeper tissues in the breast or to other organs in the body. They are sometimes called non-invasive or pre-invasive breast cancers.

### (d) Invasive (Infiltrating) Carcinoma

An invasive cancer is one that has already grown beyond the layer of cells where it started (Unlike carcinoma in situ). Most breast cancers are invasive carcinomas-either invasive ductal carcinoma or invasive lobular carcinoma.

### (e) Sarcoma

Sarcomas are cancers that start from connective tissues such as muscle tissue, fat tissue or blood vessels, Sarcomas of breast are rare.

## 1.7 Types of Breast Cancer

There are many types of breast cancer, but some of them are very rare. Sometimes a breast tumour can be a mix of these types or a mixture of invasive and in situ cancer.

    (a) **Ductal Carcinoma in Situ (DCIS):** Commonest type of non-invasive breast cancer. DCIS means that the cancer is still in the ducts and has not spread through the duct walls into the tissue of the breast. Most women having cancer at this stage can be cured. The best way to find DCIS early is with the help of a mammogram. If areas of dead or dying cancer cells are to be seen within the biopsy (when the tissue is taken out to be scrutinized in the lab) sample, then the tumour is likely to grow and spread more aggressively (quickly).

    (b) **Lobular carcinoma In Situ (LCIS):** This starts in the lobules, which are the milk making glands, but do not go pass the lobule walls. Though it is not a true cancer, it increases a women's risk of getting cancer later. Hence, for this purpose, women with LCIS must make sure they have regular mammograms and doctor visits[5].

(c) **Invasive (or infiltrating) ductal carcinoma (IDC):** It begins in the duct and breaks through the duct walls and spreads into the breast tissue and may spread to other parts of the body.

(d) **Inflammatory Breast Cancer (IBC):** It is the least common, but most aggressive of breast cancers, taking the form of sheets or nests, instead of lumps. It can start in the soft tissues of the breast, just under the skin, or it can appear in the skin.

## 1.8 Risk Factors

- Increased risk in women who begins menstruation before age 12 and late Menopause after age 55.
- Women who conceive their first child late after age 30 years develop breast cancer than who conceives a child at a younger age.
- Women with family history of breast cancer.
- Women who suffer breast cancer in one breast.
- Obese women with sedentary life style.
- Most women who develop breast cancer do not have any known risk factors or a history of the disease in their families.

## RESEARCH METHODOLOGY

### 2.1 Objectives

(a) To study the Socio-economic and Demographic Profile of the Breast Cancer Patients.
(b) To Assess the Awareness level among Breast Cancer Patients about the Breast Self Examination.
(c) To study the Support rendered by the Family Members towards Breast Cancer Patients.
(d) To study the Knowledge and Apprehensions of the Patients about their Illness.
(e) To study the Affect of Breast Cancer on the family, children and spouse of a Breast Cancer Patients.
(f) To study the Importance of Regular Screening in Breast Cancer Survivor.
(g) To undertake Twenty Case Studies for deeper understanding of Risk Factors of Breast Cancer and problems faced by Patient respondents.

### 2.2 Hypothesis

1. With the increase of age of woman the risk proneness level of Breast Cancer would also Increase.
2. Women who have had no children or who had their first child after age of 30 years have a slightly higher breast cancer risk than women having children before age 30 years.
3. Breast cancer risk is higher among women whose close blood relatives have this disease than women whose relatives are not having breast cancer.
4. Factors that may increase breast cancer risk include high fat intake, high alcohol consumption, and a diet rich in over cooked meats.

### 2.3 Pilot Study

A pilot study was conducted on 15 Breast Cancer Patients from three Hospitals i.e. Chettinad Hospital at Sholingallur, Apollo Cancer Research Center at Kottivakkam and

Cancer Research Institute Adyar (5 Patients from each Hospital) for estimating the appropriateness of statements. After Pilot study was conducted some necessary modifications were incorporated in Interview Schedule in order to enhance the **Validity and Reliability of the study.**

## 2.4 Interview Schedule

Interview Schedule has been pre-designed in a very systematic manner after conduct of Pilot Study. Interview Schedule consists of Five Parts i.e**. Part A, Part B, Part C, Part D and Part E. Part A describes Socio-economic and Demographic Profile, Part B delineates Personal History Particulars, Part C delineates Food Habits particulars, Part D describes Medical History and Part E delineates Psycho-Social Factors associated with Breast Cancer.** Interviewer asked each respondent the questions designed in Interview Schedule and noted down all the answers received from all 331 respondents.

## 2.5 Research Design

**Descriptive Research Design** has been employed for the present study. Through this design **Socio-economic and demographic conditions** of Breast Cancer Patients such as age, occupation, marital status, economic status, education, **Risk Assessment** regarding to Breast Cancer i.e. age at Menarche, age at Menopause, age at Marriage, Use of Family Planning Methods, Experience of Abortion, age at first child born, Breast fed their children, habit of smoking & Alcohol, Type of Food, History of Cancer, **Awareness on Breast Self Examination** such as Noticeable Lump, Delay in consulting a doctor and treatment, Knowledge about Illness, Knowing about Breast Prosthesis, **Affect on Family, Family Support and Apprehensions about Illness** were described in the systematic manner and further how they were associated with Breast Cancer was described in the form of tables and graphical analysis.

## 2.6 Sample Size

A total sample of 331 Breast Cancer patients i.e.  81 patients from Chettinad Hospital at Sholingallur 96 patients from Apollo Cancer Research Center at Kottivakkam and 154 patients from Cancer Research Institute Adyar were selected for the present study by adopting a **Convenience sampling method.** While selecting sample respondents a lot of care has been taken by the researcher to maintain the quality of representativeness of total population in Guntur town. **Thus, the total Sample Size of the present study was 331.**

## 2.7 Collection of Data - Primary Data

First the researcher tried to build up a very good rapport with each respondent before the commencement of Interview procedure. The researcher collected the information from each respondent by asking questions that were already designed in Interview Schedule. Primary data has been collected from 331 females Breast Cancer Patients in Greater Corporation of Chennai by adopting **pre-designed Interview Schedule**.

## 2.8 Secondary Data

Before collecting the primary data, there was great need to analyze the studies and surveys that were already conducted by experts in the subject field. For this purpose, a

literature survey was conducted by referring the secondary sources of information such as Census reports, books, research Journals, conference proceedings, web sources and other research reports so as to assess the research gap to describe the issues and factors affecting Breast Cancer.

## 2.9 Statistical Techniques – Data Analysis

Statistical techniques such as simple frequencies, percentages, Chi-square and Log it model have been employed in the present study to analyse the data.

## 2.10 Limitations of the Study

The present study is subjected to certain limitations in view of unclear nature of disclosure and nondisclosure; it was sometimes difficult to determine the true level of patient awareness of their cancer diagnosis, the limited size of the sample and limited coverage of study area only. The study is not extensive in its coverage since it is confined to only three Hospitals in Greater Corporation of Chennai and only 331 respondents were taken for the study. So, the result of the study may not be applicable to other regions in the country with varied socio-economic, demographic and geographical conditions. However, the researcher has attempted to conduct an in-depth study by covering various aspects, problems and very significant research area of Breast Cancer and their socio-economic and demographic associated factors, Psycho-socio and other Risk factors, Awareness on Brest Self Examination, Effect on Family, Family Support and Apprehensions about Illness.

## RESULT AND DISCUSSION

### 3.1 Educational Qualification

Attainment of literacy level is an important indicator of a community's social and economic status. As per the National Health Policy 2012, 35 per cent of the country is illiterate. Students are the main targets for imparting information relating to basic principles of health care. The present study in the select population in Chennai city showed that 32 per cent or 96 respondents were illiterate. And the number of respondents who were illiterate from all the four zones far outnumbered the other literate persons. And there was more number of illiterates in south or Santhome Zone than other three zones. The presence of more number of private schools than government and corporation schools in the vicinity of the select Metro Corporation area appears to be the reason for the greater level of illiteracy among the slum dwellers due to poverty. Though the number of government or corporation schools may be adequate, the improper maintenance of the school along with inadequate professionals to provide education and ill-treatment vetted to the students gives out wrong signals as to its attendance thus leading to closure of the school in due course of time.

**Table – 1:** *Literacy Level of Background in Chennai City*

| ZONES | Zone 2 | Zone 4 | Zone 7 | Zone 10 | Total |
|---|---|---|---|---|---|
| Illiterate | 24 | 25 | 17 | 30 | 96 (32.0) |
| Primary | 11 | 13 | 05 | 25 | 54 (18.0) |
| Middle | 11 | 18 | 11 | 32 | 72 (24.0) |

| | | | | | |
|---|---|---|---|---|---|
| High School | 04 | 13 | 10 | 32 | 59 (19.7) |
| Hr. Sec and Above | 03 | 03 | 04 | 09 | 19 (6.30) |
| Total | 53 | 72 | 47 | 128 | 300 (100.00) |

**Note:** *Figures in brackets represents percentage; Survey Results conducted during the present study.*

## 3.2 Household Income

The purchasing power gained by the economic activity ranges from mere food finder to huge sums of finance to fund luxurious living. At least one third of the same population did not reveal their true income. Though income of the family is camouflaged by the respondents, after much initiation, 160 of them or 53.3 per cent of the total respondents said that their earnings were between Rs.3000 to Rs.6000. Respondents having an income more than Rs.6000 included income of the other members of the family or the respondent was employed in the public or private sector. The study has showed that slums house earners of both less than Rs.150/- per day and more than Rs.52,000/- per annum. There is a need for an in-depth study as to why the rich who can afford all the amenities still thrive in the slum area. In other words, they remain a burden to the poorest of the poor who are unable to get a decent living place for themselves and their siblings. This also explains the growth of squatter settlements in and around the city.

**Table – 2:** *Household Income of Select Areas Households in Chennai City*

| Income Group | Zone 2 | Zone 4 | Zone 7 | Zone 10 | Total |
|---|---|---|---|---|---|
| Below Rs. 5000 | 13 | 15 | 12 | 36 | 76 (24.3) |
| Rs. 5000 and Rs.6000 | 31 | 40 | 21 | 68 | 160 (53.3) |
| Above Rs. 7000 | 31 | 40 | 21 | 68 | 160 (53.3) |
| Total | 53 | 72 | 47 | 128 | 300 (100.00) |

**Source:** *Survey conducted, 2015.*
**Note:** *Figures in brackets represents percentage.*

The income of the slum dwellers ranges from less than Rs.5,000/- to more than Rs.7,000/- per month. The study that there were dwellers whose income was Rs.52,000/- per month. Therefore, it can be said that income though one of the many criterion for living in Chennai city, is not the main one. The comparison between the income level and the reason for residing in the slums did not have any significance. The study showed a chi-square value of 11.345 and P-value of 0.5 for the same.

**Table – 3:** *Reasons for Residing in Chennai City*

| Reasons for residing in slums | < Rs.5000 | Rs.5000 – Rs.6000 | > Rs.7000 | Total |
|---|---|---|---|---|
| Low rent | 4 | 7 | 5 | 16 |
| Located in the center of the city | 4 | 12 | 2 | 18 |
| Since marriage | 12 | 36 | 10 | 58 |
| Since birth | 40 | 65 | 23 | 128 |

| | | | |
|---|---|---|---|
| Inherited the house | 6 | 12 | 8 | 26 |
| Migrated for job | 7 | 21 | 11 | 39 |
| Others | 3 | 7 | 5 | 15 |
| Total | 76 | 160 | 64 | 300 |

Income level sometimes makes the slum dweller to forgo treatment, particularly when it is the health of the women which is in stake. Though women are considered the head of the family, it is the husband or the father who may be the patriarch of the family. The level of the income decides the importance of the health of the women. The study found that for the health problems like urinary infection, sexually transmitted disease, menopause, etc., very few respondents approach for treatment and care. From the Table – 3, it can be observed that around 61 respondents approach the private clinic while other 62 respondents have replied to have forgone treatment. Both these respondents fall in the category of middle income group with Rs.5,000/- to Rs.7,000/- income per month.

**Table – 4:** *Approaching Health Care Institutions by Women for Urinary, Sexually Transmitted Diseases and Menopause Disorders in Chennai City Slums under the Three Income Categories*

| Health facility | < Rs.3000 | Rs.3000 to Rs.6000 | > Rs. 6000 | Total |
|---|---|---|---|---|
| Health Post | 12 | 20 | 4 | 36 |
| Government Hospital | 6 | 10 | 4 | 20 |
| Private Clinic | 25 | 61 | 27 | 113 |
| Self care | 0 | 1 | 0 | 1 |
| NGO | 1 | 6 | 2 | 9 |
| Don't know | 32 | 62 | 27 | 121 |
| Total | 76 | 160 | 64 | 300 |

So far as income is concerned, there was no significant difference in the income distribution and the health care facility approached by the women for their personal health. The study also tried to ascertain the significance with regard to the health facility approached and the health of the women with regard to their problems pertaining to menopause, cervix, vaginal discharge, etc. Among those who approach health care institutions for treatment, whether they prefer public or private health institutions, the present study showed that, out of 300 respondents, 124 of them approached private health institutions rather than public institutions as shown in Table – 5.

**Table – 5:** *Preferred Health Institutions for Women Oriented Diseases under the Three Income Categories*

| Health Facility | < Rs.3000 | Rs.3000 to Rs.6000 | > Rs.6000 | Total |
|---|---|---|---|---|
| Health Post | 10 | 24 | 4 | 38 |
| Government Hospital | 10 | 20 | 9 | 39 |

| | | | | |
|---|---|---|---|---|
| Private Clinic | 30 | 66 | 28 | 124 |
| Self care | 1 | 2 | 0 | 3 |
| NGO | 1 | 6 | 3 | 10 |
| Don't know | 24 | 42 | 20 | 86 |
| Total | 76 | 160 | 64 | 300 |

### 3.3 Caste of the Respondents

The present study has revealed that the majority of the population in slums belongs to either schedule caste or most backward classes or backward classes. The National Family Health Survey* of 2004-2005 has reported that majority of the slums in India in general and Chennai in particular is inhabited by population belonging to the schedule caste. This study too confirms the findings that the majority of the respondents, 215 out of 300, belongs to schedule castes. Most of the respondents in the north and south zones of Chennai city is fisherman whose community status is that of Schedule caste. In vernacular terms, the community which most of the slum populations belonged to is Adi Dravidar Community.

**Table – 6:** *Castes of the Respondent*

| Community | Zone 2 | Zone 4 | Zone 7 | Zone 10 | Total |
|---|---|---|---|---|---|
| Backward Class | 03 | 14 | 07 | 30 | 54 (18.0) |
| Most Backward Class | 06 | 05 | 02 | 18 | 31 (10.3) |
| SC/ST | 44 | 53 | 38 | 80 | 215 (71.7) |
| Total | 53 | 72 | 47 | 128 | 300 (100.00) |

The comparison between the community and the overall opinion about the health care services provided shows a high significance probability of 0.0001 of F probability value.

### 3.4 Availability of Health Care Services

The slum population in Chennai is provided with several heath care services through plethora of network from public sector, private practitioners, voluntary organization, industrial houses, state employees' insurance schemes, other systems of medicines, etc, as a result of flourishing amongst the general yet posh locality. A moderately poor slum household approaches the private practitioners who are available nearby at any time of the day or night. But a truly below poverty line citizen still wait for the day break to approach a government health organization to relieve of their pain.

The major provider of public health services in Chennai city are government hospitals, free of cost. The other infrastructure available is the Urban Health Posts which function at the grass root level, in addition to corporation dispensaries. Besides the public institutions, there are private practitioners having clinics, small nursing homes having limited bed facilities, bigger nursing homes catering to limited specialty services and the bigger multi-specialty hospitals providing multiple diagnostic, screening and treatment care involving huge expenses.

The public sector provides health care services like family planning, immunization activities, ante-natal, pre-natal and post-natal care, adolescent care, cancer control, and

HIV/AIDS screening, maternity benefit for poor mothers, infectious diseases control, communicable diseases control, etc, through its network of delivery systems. The other aspects of health namely the environmental sanitation, solid waste management, water supply, etc, are provided and monitored by the corporation.

The scenario sounds exciting with so many providers for health and health care services. But the true picture we get from the present study reveal certain facts. The health posts are accessed by the slum population only to fulfill the mandatory requirements of registration. The slum dwellers are excluded from the benefits such as free medical care from the government hospitals in the event, if the pregnancy is not registered with the health post of the respective jurisdiction. Hence, the slum populations either avail of the services of the government hospitals by registering in health posts located in their respective slum areas or forgo the benefits as shown in the Table 7 Registration of pregnancy is undertaken during the fourth month of pregnancy. In the event, the pregnant women approach the health post after the stipulated period; they are turned away with much empathy that the women in need shun the facility for the rest of her life.

**Table – 7:** *Frequency of Visiting Public Health Institutions for Ante-natal, Neo-natal and Post-natal Care*

| Health facility | Frequency | Percentage |
|---|---|---|
| Health Post | 167 | 55.67 |
| Government Hospital | 56 | 18.67 |
| Private clinic | 49 | 16.33 |
| Others | 28 | 9.33 |
| Total | 300 | 100.00 |

## MAJOR FINDINGS OF THE STUDY

### 4.1 Socio-Economic and Demographic Profile

- Majority (32.3%) of the respondents were found to be having higher incidence of breast cancer in the age group of 40-49 and 50-59 years followed by above 60 years age group (20.8%) and 30-39(12.7%) whereas only 1.8% of the respondents were found to be in the 20-29 age group.
- Majority (48%) of the respondents having higher incidence of breast cancer attained college education followed by primary education (27.8%), secondary education (9.7%), P.G (7.6%) While only 6.9% of the respondents found to be illiterate.
- Majority (72.8%) of the respondents were found to be housewives whereas only 1.2% of the respondents were found to be business and others.
- Majority of the respondents (93.4%) were observed as married while 2.7% of the respondents were found to be widows whereas only 0.9% of the respondents were noted as divorced.
- It was found in the study that majority (77.3%) of the respondents were living in nuclear families while 22.7% of the respondents were living in joint families.

- Majority (33.5%) of the respondents were found to be having an earning income above Rs.40000/- per month whereas only 3.6% of the respondents were having income of below Rs. 10000/-.
- Majority (84.6%) of the respondents were found to be having own house while 4.2% of the respondents were living in a mortgaged house where as 3.0% of the respondents were having other type of house.
- Majority (74.3%) of the respondents were found to be living in urban areas while remaining (25.7%) were living in rural areas.

## 4.2 Breast Cancer - Risk Assessment
- Majority (68.3%) of the respondents attained the Menarche at the age between 13 to 14 years whereas only 1.2% of the respondents attained their Menarche at the age above 16 years.
- Majority (38.1%) of the respondents reached menopause at the age between 46 to 50 years where as only 1.2% of the respondents reached their menopause at the age above 55 years.
- Majority (45.9%) of the respondents got married at the age between 16 to 20 years followed by 21-25 years (30.2%) where as 1.2% of the respondents got married at the age above 30 years while only 0.3% of the respondents were remained as unmarried.
- Majority (66.2%) of the respondents have not used any family planning methods where as 33.8% of the respondents were found to have family planning methods.
- Majority (47.7%) of *the* respondents had two children where as 12.4% of the respondents had one child while 4.2% of the respondents were found to have no children.
- Most (80.4%) of the respondents didn't undergo for any kind of abortions while others have had (19.6%) undergone abortions.
- Majority (40.5%) of the respondents expressed that their first child was born at the age between 16 to 25 years where as 3.0% of the respondents conceived their first child at the age above 30 years while 4.2% of the respondents were found to be having no children.
- Most (86.1%) of the respondents have breast fed their children while only 9.7% of the respondents have not breast fed their child.
- Most (98.5%) of the respondents did not have a habit of smoking where as 1.5% of the respondents were found to have a habit of smoking.
- Most (78.2%) of the respondents have not been exposed to passive smoking and 21.8% of them have exposed to passive smoking.
- Most (96.8%) of the respondents have never consumed alcohol while 3.0% of respondents were found to be consuming alcohol.

## 4.3 Awareness on Breast Self Examination knowledge about Illness and Follow-ups:
- Majority (72.2%) of the respondents has no knowledge about self breast examination while (27.8%) of the respondents has knowledge about self- Breast examination.
- It was found that among 27.8% of the respondents knew about breast self examination, majority (10%) of the respondents came to know breast self examination through

magazines followed by Doctors (9.4%) whereas only 1.5% of the respondents knew through others.

- It was found that majority (89.4%) of the respondents have had complaints of lump in the breast where as 0.9% of the respondents have had pain.
- Majority (75.8%) of the respondents have had a noticeable lump in the breast while 9.1% of the respondents have been found with a lump through routine check-up where as 7.6% have noticed a lump through other investigations.
- Majority (66.8%) of the respondents have undergone for FNAC followed by 16.6% of the respondents have undergone for Mammography, 15.7% of the respondents have undergone for Biopsy where as 0.9% of the respondents have undergone for PET CT scan.
- Majority (70.1%) of the respondents have delayed in consulting a doctor where as 29.9% of the respondents consulted a doctor without delay.
- Majority (47.4%) of the respondents delayed consulting a doctor after noticing a lump due to ignorance where as 3.0% of the respondents delayed consulting a doctor after noticing a lump due to non-availability of services.
- Majority (40.8%) of the respondents delayed for 1-2 months in consulting a doctor after noticing a lump where as 2.1% of the respondents delayed for 4-5 months.
- It was found in the above table that most (95.2%) of the respondents knew about their illness while only 4.8% of the respondents did not know about their illness.
- It was found that majority (51.1%) of the respondents got information about treatment options through Doctor whereas only 0.9% of the respondents got information from other sources.
- Majority (60.4%) of the respondents have had no complaint of pain where as 39.6% of the respondents have complaints of pain.
- Majority (63.4%) of the respondents did not know about breast prosthesis while 36.6% of the respondents have known about breast prosthesis.

## 4.4 Effect on Family, Support from Family, Apprehensions about Illness:

- Most (83.1%) of the respondents have had fear about the disease where as 16.9% of the respondents experienced no fear about disease.
- It was found that majority (39.3%) of the respondents have had fear of about recurrence of cancer while as 7.6% of the respondents had fear about change in appearance where as 16.9% of the respondents have had no fear.
- Majority (58.9%) of the respondents were shocked by the diagnosis, 26.9 % of the respondents were depressed while 10.6% of the respondents were Brave where as 3.6% of respondents were found to be hopeless.
- Majority (59.2%) of the respondents have shared their feelings with others in their sad time. (20.5%) of the respondents spent time sitting alone while as 14.8% of the respondents cried where as 5.4% of the respondents choose to do other activities.
- Majority (65.6%) of the respondents were mixing freely with others after their diagnosis where as 34.4% of the respondents expressed that they were not interacting freely with others after their diagnosis.

- Majority (65.6%) of the respondents mix freely with others. 12.1% of the respondents avoid due to self-appearance, 10.3% of the respondents due to ongoing conversation on the disease, 9.1% avoid people due to low self esteem, 3% of the respondents avoid due to fear of rejection.
- Majority (52%) of the respondents have received Financial support from their family followed by 31.4% of the respondents have received emotional while 16.6% of respondents received informational support.
- Majority (96.4%) of the respondents were obtained information about treatment in every visit, (2.4%) of the respondents obtained information about treatment Monthly where as 1.2% of the respondents were getting information about treatment weekly once.
- Majority (56.8%) of the respondents have not enquired about any alternative treatment options while 22.7% have considered Ayurveda as an alternate mode of treatment where as 0.3% of the respondents have considered Naturopathy.
- Majority (78.5%) of the respondents have never interacted with other survivors of breast cancer while remaining 21.5% of the respondents have interacted with other survivor of breast cancer.
- It was found in the study that 20.5% of the respondents felt that interacting with other breast cancer survivors gave a boost to their confidence where as 0.9% of the respondents who felt that interacting with other breast cancer survivors did not help their confidence while 78.5% of the respondents never spoke to any breast cancer survivors.
- Most (99.1%) of the respondents did not join any support group where as 0.9% of the respondents have joined a support group.

## CANCER PREVENTION

- **Avoid:** Any form of tobacco should be avoided. It is a major risk factor for cancer. Smoking in both forms, passive and active must be stopped. Also chewing tobacco will cause cancer.
- **Food:** The most important thing it to eat healthy foods which contains grains, fruits and vegetables. It is recommended to not consume red meat. Alcohol should strictly be avoided. Consumption of fatty foods is not recommended.
- **Exercise:** Exercising regularly will help in preventing formation of fat in our body. Daily exercise must be an essential extent of one's daily routine.
- **Sunlight:** The UV rays which are emitted from Sun, is a major cause of skin cancer. It is advised to avoid the sun's ultraviolet rays, specifically between 10 am to 4 pm. It is also suggested to apply ample amounts of sunscreen lotion before going outdoors during the peak hours.
- **Immunization**: Getting vaccinated against Hepatitis B will reduce the infection which will cause liver cancer.
- **Health:** Sexually transmitted diseases, for example: human papilloma virus infection, hepatitis B and HIV can be avoided by practicing safe sex. These STDs can be a cause to various types of cancers. This can be achieved by using condoms and limiting the

number of sexual partners. If drug usage is present, do not share the needles and immediately seek professional help.

- **Annual check-ups:** We need to make a habit of going for our annual medical check-ups. These regular checks can detect cancer at early stages which will help in better treatment options.

## STRATEGIES

1) **Creating awareness** about cancer is the most important part of the life of an individual. Early detection of cancer helps an individual to get cured. To create awareness in women and educate them regarding breast self examination and risk factors of breast cancer for early detection with the help of health workers and volunteers. To include more NGO's to create awareness and screening in areas where tertiary care of hospitals is not available.

2) **Adopt a healthy life style** to reduce the risk of breast cancer which includes maintaining a healthy weight, regular exercises and avoid fried items. Conduct a breast self examination, clinical breast examination and get regular screening mammography every year.

3) **To promote the necessity of modifiable risk factors** like avoiding smoking, alcohol and take less fat high fiber diet. Promote healthy diet inclusive of lots of green vegetables follows high nutrient diet. Changes in diet and life style to reduce the incidence of cancer.

4) **Women who are having history of breast cancer** in their family should go for screening like mammography or clinical examination advised by their physician.

5) **To promote the importance of having children before the age of 30 years**. Breast feeding also contributes to risk reduction. Women who have used Hormone replacement therapies are at risk that risk increases with increasing Duration of hormone replacement therapy.

6) **Training should be available** for doctors, paramedical personnel and social Workers from voluntary and government organizations to impact training in Breast cancer awareness and psychosocial problems of patients who suffered with breast cancer. People should be oriented through media, booklets, radio and etc.

7) **Psychological issues are associated with breast cancer**, which creates fear in them. After completion of treatment also most of them have fear about recurrence. Social workers or volunteers should conduct group sessions for those who are having same type of cancer. Cleared their misconceptions and motivate them towards positive attitude.

8) **A multidisplinary team support is necessary** in every area to avail quality medical treatment to overcome the burden of cancer.

9) **Social media should play a responsible role** in creating awareness and indulging group activities for breast cancer survivors to overcome their feelings.

10) **Information about facilities necessary in post breast cancer treatment** should be increased. Educating them use of breast prosthesis and wigs should be encouraged to improve their self consciousness.

11) **Follow-up care is very important after treatment** to identify the recurrence early. Government should provide facilities like mammography, MRI in district hospitals also.

12) **Health of women depends** on the prevailing economic, political, social, cultural, educational, and physical environment. This multi-dimensional supportive environment needs to be planned and developed by the individual, family, community, and institutions, NGO's, Governments and International Organizations for the welfare and care of the Breast Cancer Patients.

13) **Promotion of health is the most important** part of the total health care of the Breast Cancer Patients. To maintain and promote health during treatment, it is vital to prevent diseases and disability. Early detection and appropriate care should follow when preventive measures taken up, 50 percent or more of all the health problems are preventable. Positive attitude towards life coupled with exercise and good nutrition makes a big difference in your overall Quality.

## SUGGESTIONS

In order to reduce aging problems of the Breast Cancer Patients such as biological, i.e. health problems, arising out of their early menarche, late menopause, abortion, consuming fatty food and alcohol, passive smoking, the economic problem due to the reduction in the income level and psychosocial and cultural problems arising during the treatment and life in the modem family, the following ways and means of their mitigation seem to be more wise, useful and highly redeeming:

1) **Mobile units should be arranged** in every district and awareness classes should be arranged for the public in the field of oncology. Create awareness among educated and non-educated women regarding breast self examination for early detection. Government should create awareness and screening methods in rural area also with the help of health volunteers.

2) **The family members should be made aware** of psychological and health problems of the breast cancer patients and in such a way that they should take

3) a sympathetic attitude towards the patients.

4) **The government should give incentives** to families which take care of cancer patients like income tax relief, monetary benefits etc.

5) **Patients who are physically and mentally fit** to work should be helped in finding out some remunerative work full time or part time in the field or their interest and ability. This will help them in reducing their feeling of dependency on others can be productive.

6) **The government should consider and provide** free or at least subsidized Facilities for their travelling.

7) **Everyone should take less fat and more fiber diet**. Avoid of taking fast foods and fried items.

8) **Motivation is important during their treatment** and helps to complete it. Counselors or doctors should work to motivate the patient and family members about the support and how it helps the patient.

9) **The cancer support team should explain** the importance of regular follow-ups during their treatment and after completion of treatment and explain the role of regular follow-ups in diagnosing early recurrence.

10) **Government should provide chemo drugs** to less cost and health policies or schemes for decreasing the financial constraint on patient its families.

11) **Government should take up measures** to start well equipped oncology

12) Clinics in every district hospitals.

13) **Organizational frame work and programmes at central and state**
   (a) National Board for senior citizens.
   (b) National Institute for senior citizens.

## FUTURE ACTIONS FOR THE BREAST CANCER PROBLEM

Considering the increasing number of Breast Cancer Patients and their near total economic dependence and increasing their psycho- social problems security plans for them to be taken up in a big way. Future actions can include two types of programmes – those Generating awareness among young girls (such as rallies, poster competitions and symposium) and more organized moves need to be made to meet the demands of the Breast Cancer Patients. More involvement of the nation and the society is needed in terms of finance and services. The rich and the privileged classes may be able to arrange for their welfare but the poor and down trodden, more so the women, really need all help in their vulnerable conditions. The following steps can be taken in future studies for ameliorating the vulnerable conditions and Preventive Measures for Minimizing Brest Cancer problem.

1) To increase the awareness among all women about Breast Self Examination.
2) To study whether any modifiable risk factors can be curtailed.

## CONCLUSION

From the above discussion, it can be concluded that the present study that was conducted on psycho social factors that affect breast cancer patients has revealed that as the age increases the risk of the breast cancer also increases. The incidence of breast cancer was found to be more in urban areas, among highly educated and high income women group when compared with that of women from rural areas, uneducated and low income group women respectively. The risk of developing breast cancer was not associated with presence of cancer in family and the result of this study did not find early menarche and late menopause to be risk factors for breast cancer but the risk increases moderately with consumption of oil and fatty foods. The majority of respondents were not having knowledge about breast self examination and subsequently delayed in consulting a doctor even after noticing a lump. Respondents expressed that they did not use any family planning methods and further they expressed that they did not smoke or consume alcohol.

The importance of this study was to evaluate the factors which affect the psycho social barrier in breast cancer and establish a multi dimensional and effective means to elevate and improve the breast cancer patient's quality of life basing on this. On another note the differences in the research results might be from different approaches to statistical data analysis. The emotional stress of living with a diagnosis of cancer and its treatment, fear of

recurrence, and the distress imposed by living with the day-to-day physical problems described above can create new or worsen pre-existing psychological distress for people living with cancer, their families, and other informal caregivers. Physical and psychological impairments can also lead to substantial social problems, such as the inability to work or fulfill other normative social roles.

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